



ARMY MEDICINE
Serving To Heal...Honored To Serve

Patient Safety

**Clinical Performance Assurance
Directorate
HQ, US Army Medical Command**



Purpose & Terminal Learning Objectives

PURPOSE: To provide information on the Patient Safety (PS) Program in the US Army Medical Department

The Learner will be able to:

- Gain an understanding of the PS program's Mission, Vision and Goals
- Identify how medical & dental PS fall within the Army Medicine Strategy Map, plus the Quadruple AIM and Quality Iceberg models
- Understand the past and present of PS
- Articulate how leadership positions, engagement and strategies fit into effective PS programs
- Identify various types of PS cultures
- List the PS "Tools of the Trade"
- Locate PS information thru the Quality Management Office website



PATIENT SAFETY PROGRAM

Mission

Establish an environment of trust, transparency, teamwork and communication to facilitate an interdisciplinary proactive approach to improving safety and preventing adverse events.

Vision

America's premier Patient Safety Program inspiring trust in Army

Goals

Engage leadership at all levels to foster a culture of Patient Safety
Analyze AMEDD Patient Safety cultural elements to drive program initiatives

Integrate teamwork concepts, knowledge, skills and attitudes to improve the quality of Patient Safety

Provide facilities with meaningful data to identify and mitigate patient safety risks.

Army Medicine Strategy Map

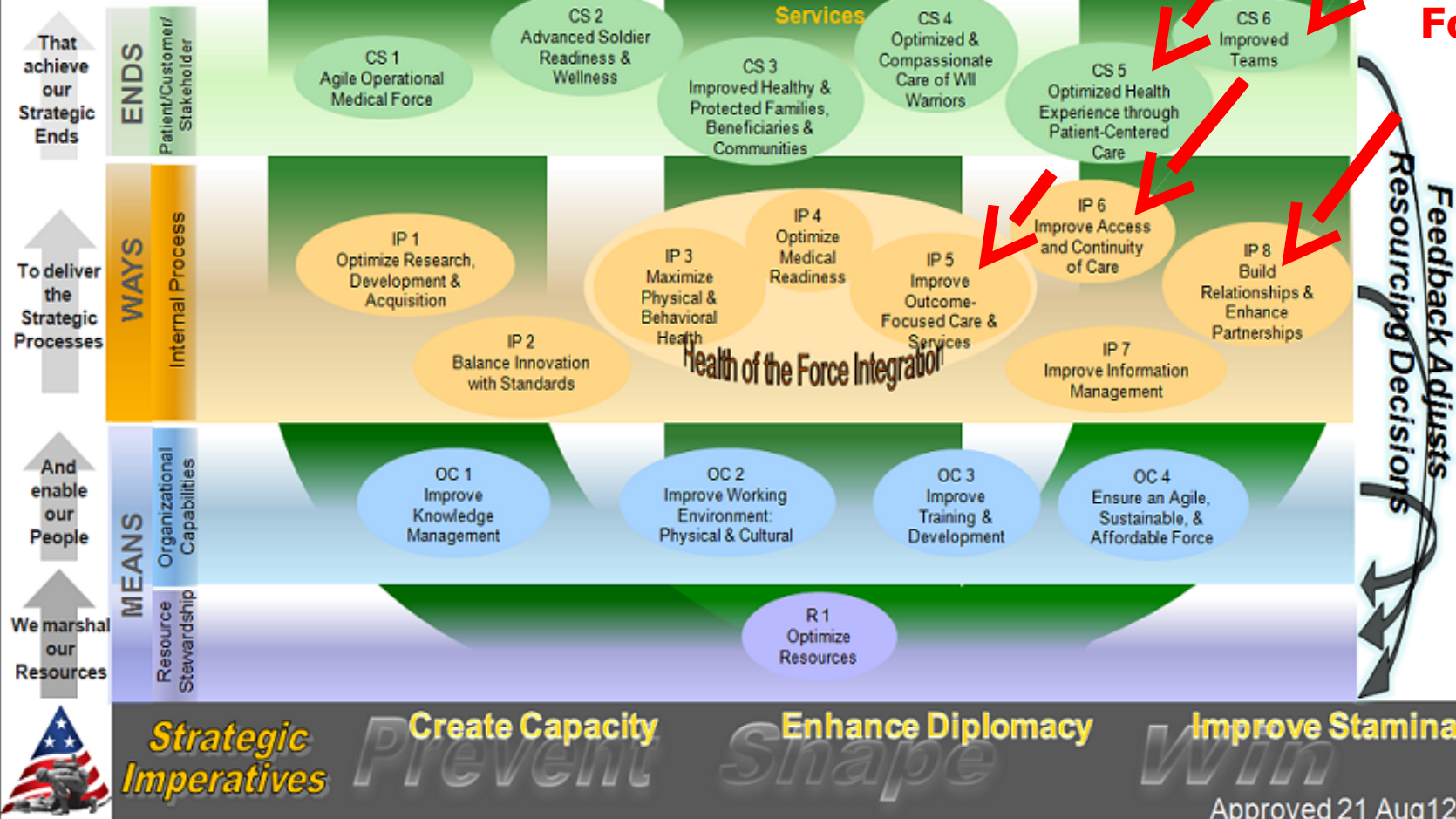
Vision

Strengthening the *Health* of our Nation
by improving the *Health* of our Army

Mission

Army Medicine provides responsive and reliable health services and influences *Health* to improve readiness, save lives, and advance wellness in support of the Force, Military Families, and all those entrusted to our care.

Lines of Effort



Approved 21 Aug12



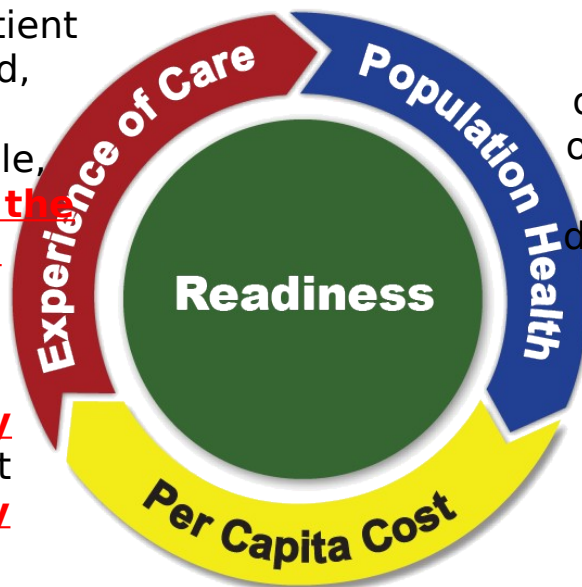
MILITARY HEALTH SYSTEM (MHS) QUADRUPLE AIM

Experience of Care

Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe and always of the highest quality.

Readiness

Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.



Population Health

Reducing the generators of ill health by encouraging healthy behaviors and decreasing the likelihood of illness through focused prevention and the development of increased resilience.

Per Capita Cost

Creating value by focusing on quality, eliminating waste, and reducing unwarranted variation; considering the total cost of care over time, not just the cost of an individual health care activity.

MHS leadership identified the Patient Centered Medical Home model for primary care as a key enabler of the Quadruple Aim.



Dental & Medical Patient Safety

- Prevention of Harm Events
- Best/Lead Practices
- Policies
- Support



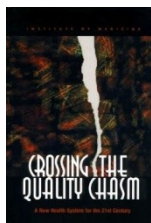


Patient Safety Timeline



is Human

IOM
Report:
98,000
preventable
deaths
@ \$17-
2B/yr; 10-
35%
preventable
ADEs;
Nococomi
als 90,000
deaths/yr
@ \$2M



Urgent call for a
redesign of the US
healthcare system



Patient Safety &
Quality
Improvement Act



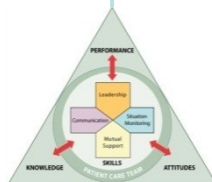
Congressional
Mandate to
Conduct Team
Training in DoD



Authentication
Act
Mandated:
Reporting &
Analysis,
Culture
Change
Program, and
Teamwork



PS Culture Survey



TeamSTEPPS



PS Culture Survey



PS Culture Survey



Affordable Care
Act Signed



Sustainment

1999

2000

2001 2003 2005

2008 2010 2011

2012 2013



Leadership Engagement



[HOME](#) | [SEARCH](#) | [CONTACT US](#) | [SITE MAP](#) | [CAREERS](#) | [NEWSROOM](#) | [QUALITY CHECK](#)



[Printer-Friendly](#) [Home](#) > [Sentinel Event](#) > [Sentinel Event Alert](#)

August 27, 2009

Issue 43, August 27, 2009

Revised September 8, 2009*

[Advisory Group](#)
[Forms and Tools](#)
[Policy and](#)
[Procedures](#)
[Reporting](#)
[Alternatives](#)
[Sentinel Event](#)
[Alert](#)
[Statistics](#)

Leadership committed to safety

Leadership is a critical function in promoting high quality, safe health care. In health care organizations, leadership is provided by the governing body, the chief executive and senior managers, and the leaders of the clinical staff. When a sentinel event occurs in a health care organization, inadequate or ineffective leadership is often one of the contributing factors. In fact, inadequate leadership was a contributing factor in 50 percent of the sentinel events reported to The Joint Commission in 2006. (1) Research shows that leadership makes a major difference in the quality and safety of patient care. (2,3,4,5,6,7,8) "Leaders must recognize that all sentinel events involve a failure in the systems and processes which led to the event," says Jeff Selberg, CEO of Exempla Healthcare. "As leaders, we are accountable for those systems and processes which provide the framework for the clinical environment our staff works within. My first priority is to understand how we improve our clinical environment to reduce the possibility of doing harm."

Health care organizations have not developed the "zero-defect" safety interventions seen in other high-risk industries such as aviation, energy and manufacturing. (8,9) But health care is moving in that direction. Progressive health care leaders have begun to apply lessons learned in other industries to reduce risk and strengthen the defenses against preventable patient harm in health care environments. (2,3,8)

According to TJC, **inadequate leadership was a contributing factor** in 50% of the sentinel events reported.

Leaders makes a difference

Leaders are accountable

Per: A Guide to TJC Leadership Standards

- > **Shared vision, goals & plan**
- > **Clarity about each member's role**
- > **Individual competence**
- > **Understanding roles, strengths & weaknesses**
- > **Effective communication**
- > **Monitoring each others functions**
- > **Backing up each other**
- > **Mutual trust**

The Governance Institute®
The essential resource for governance knowledge and solutions



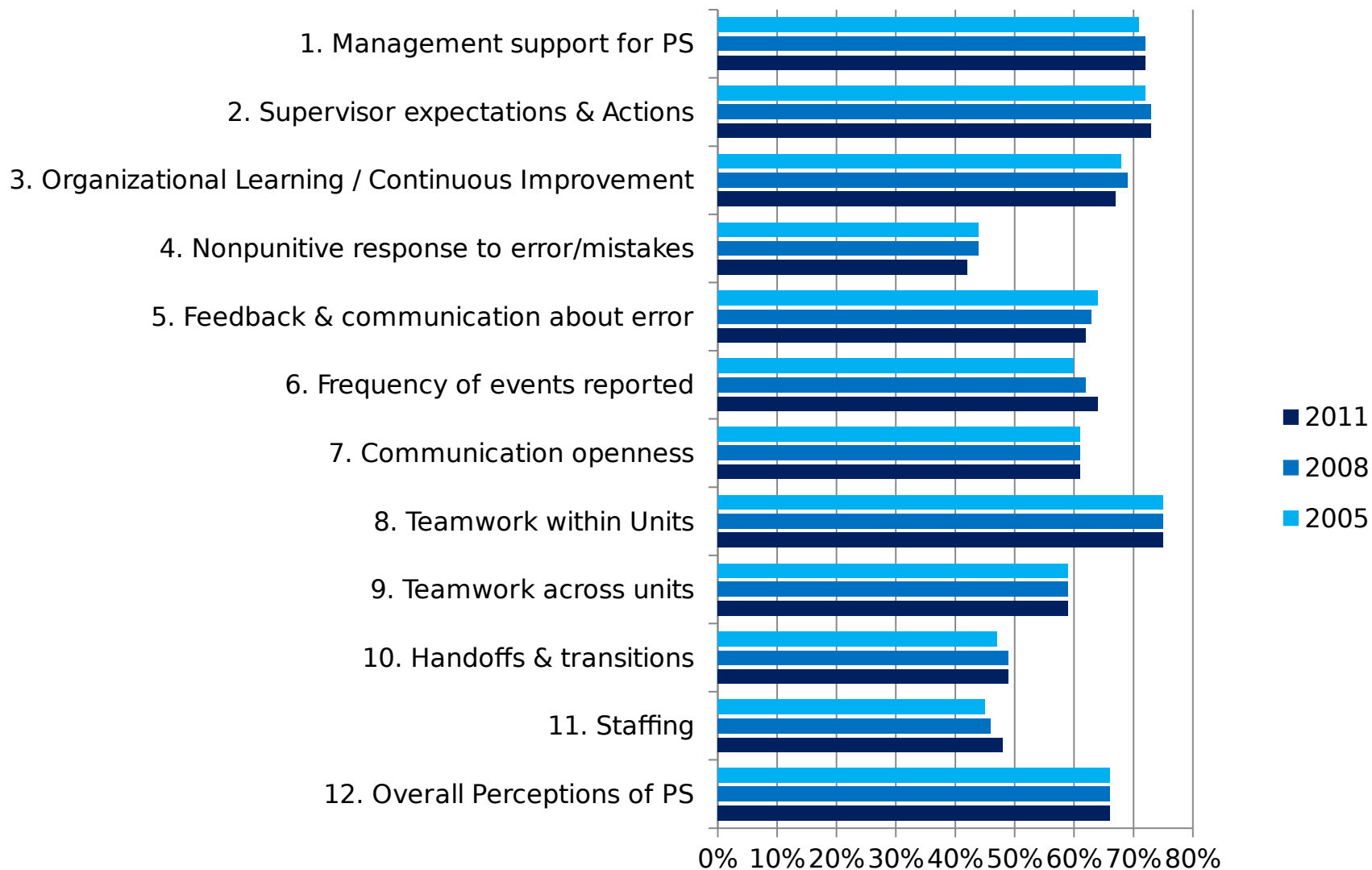
Patient Safety Leadership Strategies

- **Core Value Belief** - Practice Patient Safety & Quality Care
- **Confront Behaviors At All Levels** - That undermine a culture of safety
- **Report** - Sentinel Events and Near Misses (Close Calls)
- **Prioritize Patient Safety** - Put on committee meeting agendas
- **Visit High Risk Areas** - OR, ICU, OB, ED, Cath & GI Lab, others...
- **Daily** - Briefs, huddles, and debriefs
- **Know** - Your Patient Safety Manager
- **Remember** - Quality & Patient Safety are less expensive





MHS Patient Safety Culture Survey





Patient Safety “Tools of the Trade”

- Data
- Patient Safety Reporting System
- Partnership for Patients
- The Joint Commission
- National Patient Safety Goals
- Root Cause Analysis/Sentinel Events
- Policies
- Teaching/Lecturing
- TeamSTEPPS & Coaching
- Pharmaco-Vigilance Center
- Newsletters, Graphics, Logos, Pamphlets
- National PS Awareness Week
- Quality Iceberg
- Just Culture
- QMO site





Data Collecting, Trending & Reporting

Report Event : Login : Register

18 November 2010 Datix

△ Patient Safety Event Reporting Form
Reporting is anonymous unless reporter detail is completed
A * indicates a required field.
Click the ? icon for help with a particular field.
Click the "F" button to view and select from the list of available filters for that field.
Once submitted the event report is linked. User may not save draft report.
Issues with the PSR system should be reported to the Help Desk:
Send email to info@psr.com and/or info@psr.com and/or call 1-800-800-8000.

Event details
This section asks you to detail Where, When and What happened.

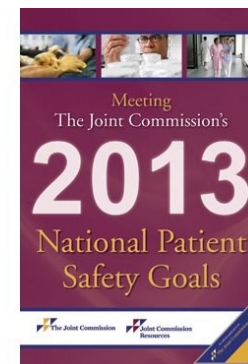
* Event date

* Event time

* Event time (24 Hour Clock)

Discovery date

* Service Affiliation



- Patient Safety Reporting System
- Partnership for Patients
- The Joint Commission Surveys
- National Patient Safety Goals
- Sentinel Events, Root Cause Analysis
- Military Health Systems, DoD, Army, Navy, AF





Patient Safety Reporting System (PSR)

- Centralized patient safety reporting and analysis
- Secured, web based reporting
- Standardized across the Military Healthcare System
- Used to capture, track and trend healthcare events
- Used to report medication and non-medication events
- Used to report near misses, close calls, good catches
- Used by Army, Navy and Air Force
- Used at US & overseas military hospitals
- Autonomous Reporting

PSR

16 November 2010 Datix

Report Event : Login : Register

△ Patient Safety Event Reporting Form

Reporting is anonymous unless reporter detail is completed

A * indicates a required field.

Click the ? icon for help with a particular field.

Click the [X] button to view and select from the list of available options for that field.

Once submitted the event report is locked. User may not save draft report.

Issues with the PSR system should be reported to the MHS Help Desk:
Send email to mhsc@timpo.osd.mil or mhs_remedy@timpo.osd.mil or call 1-800-600-9332.

Event details

This section asks you to detail When, Where and What happened.

* Event date (mm/dd/yyyy) [input field]

* Event time (24 hour local time) [input field]

Discovery date (mm/dd/yyyy) [input field]

* Service Affiliation [input field]

PSR System



Partnership for Patients

Public-private partnership that will:

Save lives

Prevent injuries

Improve patient outcomes

Tri-service implementation

Goals:

Decrease preventable hospital-acquired conditions

Decrease preventable complications during a transition from one care setting to another so that all hospital readmissions decrease



- Hospital-Acquired Conditions:
 - Adverse Drug Events
 - Catheter-Associated Urinary Tract Infections
 - Central Line Associated Blood Stream Infections
 - Injuries from Falls and Immobility
 - Obstetrical Adverse Events
 - Pressure Ulcers
 - Surgical Site Infections
 - Venous Thromboembolism
 - Ventilator-Associated Pneumonia



The Joint Commission

“Despite best efforts, serious quality and safety problems persist”
“Routine safety processes break down”
“Bad things still happen in good hospitals”

Dr. Mark R. Chassin, MD, MPP, MPH
President, The Joint Commission

- Analyze TJC findings
- Recommend improvements
- Coordinate accreditation activities at M
- Consultant for complaints to TJC





The National Patient Safety Goals 2013

- **Identify Patients Correctly**

- Two patient identifiers
- Correct patient, correct blood

- **Improve Staff Communication**

- Critical results to the right staff person, on time

- **Use Medicines Safety**

- Label medicines
- Anticoagulant precautions
- Medication reconciliation



- **Prevent Infection** (use proven guidelines)

- Hand washing (CDC & WHO)
- Difficult to treat infections
- Blood from central line infections
- Post surgical infections
- UTIs caused by catheters

- **Prevent Mistakes In Surgery**

- Correct surgery, patient, place on body
- Correct mark (mark the site)
- Pause before surgery (Time Out)

- **Identify Patient Safety Risks**

- Find out which patients are more likely to attempt suicide



New National Patient Safety Goal (2014)

Prepublication Requirements

**Ignoring
Alarms**

**Difficult to
Detect**

**Multi-faceted
Problem**

**Not Properly
Managed**

**Numerous
Alarms**

National Patient Safety Goal on Alarm Management

**Desensitized
staff**

**Disabling
Alarms**

NPSG.06.01.01

Improve the safety of clinical

Rationale for NPSG.06.01.01

Clinical alarm systems are a source of potential patient problems. If not properly managed, they can compromise patient safety. This is a multi-faceted problem. In some situations, alarms are difficult to detect. At the same time, many patients have numerous alarm

atic, coordinated approach to clinical alarm system management. Standardization contributes to safe alarm management. It is recognized that solutions are needed for specific clinical units and patients. This NPSG focuses on alarm systems that have the most potential for harm. The system manager should update

A 1. Establish alarm system safety as a hospital priority. **R**
A 2. Identify the most important alarm signals to be based on the following: **R**

- Input from the medical staff and clinical departments



Alarm Management

Phase I (beginning January 2014), hospitals will be required to **establish alarms** as an organization priority and **identify the most important alarms** to manage based on their own internal situations.

Phase II (beginning January 2016), hospitals will be expected to **develop** and implement specific components **of policies and procedures. Education** of those in the organization about alarm system management will also be required in January 2016.





Root Cause Analysis / Sentinel Events

- Facilitates Investigations for Sentinel Events
- TapRootT Software
 - Drives Corrective Actions
- RCA
 - Tracks & Investigates
 - Measures & Reports
 - Resolves & Improves





Policies

- Review
- Update
- Staff
- Publish
- Disseminate

<p style="text-align: right;">*MEDCOM Reg 40-41</p> <p style="text-align: center;">DEPARTMENT OF THE ARMY HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND 2748 Worth Road JBSA Fort Sam Houston, Texas 78234-6000</p> <p>MEDCOM Regulation No. 40-41</p> <p style="text-align: right;">8 May 2013</p> <p style="text-align: center;">Medical Services THE PATIENT SAFETY PROGRAM</p> <p>Supplementation of this regulation and establishment of forms other than MEDCOM forms are prohibited without prior approval from HQ MEDCOM, ATTN: MCHO-CL-Q.</p> <p>1. History. This issue publishes a revision.</p>	
<p style="text-align: center;"> DEPARTMENT OF THE ARMY HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND 4201 GEORGIA CIRCLE, SUITE 1000 FORT SAM HOUSTON, TEXAS 78234</p> <p>MCDS</p> <p style="text-align: right;">26 April 2011</p> <p>MEMORANDUM FOR All U.S. Army Dental Command Personnel</p> <p>SUBJECT: U.S. Army Dental Command (DENCOM) Policy 2011-49, Correct Site Surgery</p> <p>1. References:</p> <ul style="list-style-type: none">a. U.S. Army Medical Command (MEDCOM) Regulation 40-41, Medical Services, The Patient Safety Program, 14 Jan 02.b. MEDCOM Regulation 40-54, Medical Services, Universal Protocol: Procedure Verification Policy, 23 Feb 09.c. MEDCOM Memorandum, Mandatory Use of TapRoot® and Root Cause Analysis (RCA) Submission Requirements, 19 May 06.d. OTSG Memorandum, Mandatory Use of Full Patient Name and Date of Birth for Patient Identification, 23 Feb 09.e. NCC MERP Index for Categorizing Medication Errors. National Coordinating Council for Medical Error Reporting and Prevention, Dec 05. <p>2. Purpose: To provide DENCOM guidance on correct site surgery verification to military, Department of the Army (DA) civilian, and contract service providers working within DENCOM facilities.</p> <p>3. Policy:</p> <ul style="list-style-type: none">a. Patient safety (PS) is a top priority in DENCOM and an integral part of quality dental health care. DENCOM relies on the leadership at all levels to promote responsible identification and reporting of PS issues, foster a culture of safety, and continually identify opportunities to improve and assure PS. Each dental staff member has an equal voice in discussing PS concerns and identifying ways to improve PS.b. Wrong site surgery is a broad term encompassing all surgeries or treatment procedures performed on the wrong patient, wrong body part, wrong side of the body, or at the wrong level of the correctly identified anatomic site. Examples of wrong site surgery include extraction of the wrong tooth, cavity preparation on the wrong tooth or	<p>Medical Department (AMEDD) report actual and potential events patient safety (PS) and</p> <p>struction (DODI) 6025.13, Confidentiality of medical quality (SC), Section 1102 (10 USC</p> <p>all U.S. Army Medical</p> <p>uses leadership engagement, evaluate, and execute process harm to beneficiaries.</p> <p>14 January 2002.</p>
<p style="text-align: right;">Army Regulation 40-68</p> <p style="text-align: center;">Medical Services</p> <p style="text-align: center;">Clinical Quality Management</p> <p style="text-align: right;">Revision (RAR) Issue Date: 22 May 2009</p> <p style="text-align: right;">Headquarters Department of the Army Washington, DC 28 February 2004</p> <p style="text-align: center;">UNCLASSIFIED</p>	



Teaching / Lecturing

- BOLC (Medical & Dental)
- OIC/NCOIC Course
- Case Managers Course
- Dental Management Developmental Course
- Entry Level Executive Nursing Course
- Pre Command Course
- Annual Patient Safety / Risk Management Conference

- Average Daily Student Load of Over 5,500
- Over 2500 Faculty and Staff
- 315 Programs of Instruction





TeamSTEPPS

Evidenced based teamwork system that the applies tools and strategies of high performing teams.

The goal is to produce highly effective medical teams that optimize the use of information, people, and resources to achieve the best clinical outcomes for our beneficiaries.

High performing medical teams compensate for individual fallibility and dramatically reduce the consequences of inevitable human error, resulting in enhanced safety and improved performance

TeamSTEPPS

Team **S**trategies
and **T**ools to
Enhance
Performance and
Patient **S**afety



TeamSTEPPS

- 2011 – OTSG mandated TeamSTEPPS culture implementation
- 2013 – Nearly 80% AD trained & Implemented in the Army Reserves
- Present – Pilot for Surgical Simulation Training
- Plan – Implement at AMEDD C&S





Coaching

- Coaching calls for:
 - Patient Safety Managers
 - Basic Patient Safety Manager Course student follow-up
 - TeamSTEPPS preparation and follow-up
 - Support
 - Facilitation





Pharmaco-Vigilance Center

- Drug Safety Communication
- Manufacturers Newsletters
- FDA Drug Warnings



January 22, 2013

IMPORTANT DRUG WARNING

Potential Risk of Liver Injury with Use of SAMSCA® (tolvaptan)

Dear Healthcare Provider,

Otsuka would like to inform you of significant liver injury associated with the use of SAMSCA (tolvaptan).

In a large double-blind, 3-year, placebo-controlled trial (TEMPO 3:4)¹ in about 1400 patients with Autosomal Dominant Polycystic Kidney Disease (ADPKD) and its open-label extension trial in patients, 3 patients treated with SAMSCA (tolvaptan) developed significant (>3x ULN) increases in serum alanine aminotransferase (ALT) with concomitant, clinically significant (>2x ULN) increases in serum total bilirubin. Following discontinuation of treatment, all 3 patients improved. An external panel of liver experts assessed these 3 cases as being either probably or highly likely to be caused by tolvaptan. These findings indicate that SAMSCA (tolvaptan) has the potential to cause irreversible and potentially fatal liver injury.

Additionally, SAMSCA (tolvaptan) was associated with an increased incidence compared to placebo of significant (greater than 3x ULN) elevations of ALT. Specifically, 4.4% (42/958) of ADPKD patients on SAMSCA (tolvaptan) and 1.0% (5/494) of patients on placebo exhibited elevations greater than 3x ULN of ALT. Most of the liver enzyme abnormalities were observed during the first 18 months of therapy. The elevations gradually improved after discontinuation of tolvaptan. In the ADPKD trials the maximum daily dose of SAMSCA administered (90 mg in the morning and 30 mg in the afternoon) was higher than the maximum 60 mg daily dose approved for the treatment of hyponatremia.

SAMSCA is not approved for the treatment of ADPKD.

In other clinical trials of SAMSCA, including the trials supporting the approved indication (clinically significant euvolemic or hypovolemic hyponatremia), liver damage has not been reported.^{2,3}

Otsuka America Pharmaceutical, Inc.
One University Square Drive, Suite 500 • Princeton, NJ 08540 • Main: 609-524-6788 • Fax: 609-955-3368 • www.otsuka-us.com

PHARMACOVIGILANCE CENTER SAFETY COMMUNICATION

No. 1 January 2013

Single-ingredient long-acting beta-agonist use in the Military Health System (MHS)

Long-acting beta-agonists (LABAs) are a class of drugs used to treat patients with asthma or chronic obstructive pulmonary disease (COPD). Because data show that LABA use has been associated with increased risk of hospitalizations, intubations, and death from asthma, the Food and Drug Administration (FDA) released a safety communication on February 18, 2010¹ followed by a label change to all LABA products (finalized June 2, 2010)² stating that single-ingredient LABA use is contraindicated in asthma patients. LABAs should only be used in conjunction with a long-term asthma controller medication (LTACM), usually an inhaled corticosteroid (ICS). The FDA recommends that LABAs be prescribed in a product that combines the LABA with an ICS. The label changes apply to treatment of asthma but not COPD. This communication describes results from an observational study using MHS administrative claims to determine the proportion of LABA dispensed as single-ingredient. The specialty of the provider that prescribed the LABA was evaluated, where possible.

The Army Pharmacovigilance Center (PVC) evaluated the proportion of LABAs that were dispensed as single-ingredients to asthma patients within the MHS before and after the label change. Administrative data from patient interactions with the MHS,

including diagnostic codes, procedure codes, and prescription information, were used to select asthma patients (International Classification of Disease, 9th revision [ICD-9] code 493.xx in the year before the LABA) who filled a LABA from 01JAN2006 to 30SEP2011. Patients ages 65 and older or those with codes for COPD (491.xx, 492.xx, 496.xx) were excluded to limit the evaluation to LABA prescribed for asthma rather than for COPD. Prescriptions dispensed within MTF outpatient clinics were linked to the patient medical encounter at the time the LABA was written to determine the prescriber specialty. The LABA prescriptions considered in our evaluation were only included if the patient was continuously eligible for enrollment in the MHS, was not outside the continental US (OCONUS), and was not deployed for the 365 days prior to their LABA. These inclusion criteria improved the likelihood of capturing asthma patients while excluding COPD patients. Single-ingredient LABA was defined as any LABA dispensed to a patient who did not have an overlapping ICS prescription based on dispensed pharmacy administrative records. This measure may

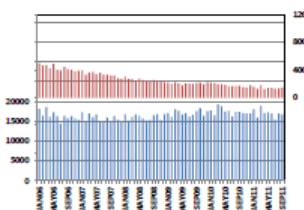


Figure 1. Total (blue) and single-ingredient (red) LABA dispensations among asthma patients in the MHS; 01JAN2006-30SEP2011



Newsletters

- “Patient Safety Newsletter”
 - Articles, Success Stories
 - Updates, Announcements
- “The Root Cause”
 - To educate at **all levels**
 - 2 page, Quarterly
 - Informational & Transparent



1 May 2013	
CONTENTS	
PSR: Email Notification	2
Upcoming Educational Opportunities	2
Targeted Solutions Tool™	2
Just Culture: A Big Hit	2
NPSAW: Poster Contest Winners	3
TapRoot Hints	4
PS Educational Opportunities	4
PSP Contact Information	4

PLAY IT SAFE!
MAY IS MEDICATION RECONCILIATION MONTH

National Patient Safety Awareness Week March 2013

National Patient Safety Awareness Week was observed this year from 3-9 March. Our facilities presented all types of activities to educate and inform staff and patients on the importance of Patient Safety year round. At Fort Leonard Wood ACH, they created a large banner



and then had the hospital staff sign the banner to signify that they were committed to 365 days of safe health care.

The Fort Gordon Dental Activity observed NPSAW by creating a display used during their Dining Out to celebrate the



102nd Anniversary of the Army Dental Corps on 8 March 2013. Along with various handouts they



presented posters for the poster contest.

The SAMMC Patient Safety staff kicked off NPSAW with presentations by various departments: remarks by the Commander and CPT Gwendolyn Godlock-SAMMC PSM, presented “Fred the TeamSTEPS Champion”.

Fred is a 5 foot 5 inch penguin that will be presented to leaders in selected clinical and non-clinical departments. They will



display the penguin in their area for 25 days.

Continued on page 2 NPSAW

12 July 2013

Volume 1, Issue 1

Prevention of Wrong Site Surgeries (WSS)

What is a WSS? One of the most common Army sentinel events is an event that is defined as a wrong-site surgery (WSS). The Joint Commission defines WSS as “any surgery performed on the wrong site or patient, or performance of the wrong procedure.” WSS can be: (1) Incorrect side [i.e.] left rather than the correct right side, (2) Correct side but incorrect location/site [i.e.] incorrect finger but correct hand, (3) Correct side and site but incorrect procedure [i.e.] resection of a muscle instead of recession, or (4) Wrong patient.

Army Reports Increase in Wrong Site Surgeries: Over 30 medical and dental WSS have been reported from FY2011 through June 2013. Each was preventable. It’s essential to refocus on how we can prevent these events.

The following 4 WSS SE case summaries show:

- (1) Ineffective timeout procedures
- (2) Complacency
- (3) Inattention to detail
- (4) Poor communication

Most frequently reported Causal Factors:

- (1) Ineffective use of Universal Protocol
- (2) Work place distractions
- (3) Ineffective communication between health care providers, health care teams

Case 1: A patient with dyspnea & history of metastatic lung cancer went to Interventional Radiology for a (patient’s) right thoracentesis (a previous CT & US confirmed fluid). The patient consented and the patient’s left side prepped. A “final time out” was done with documentation for the patient’s right side. The needle was inserted on the patient’s left side without fluid return.

Case 2: A patient was scheduled for biopsies for suspected metastatic lesions on the left side of her 12th thoracic vertebrae and on the right side of her 3rd lumbar vertebrae. The biopsies were taken from the correct levels, but on the wrong sides.

Case 3: Patient presented for restoration of tooth #20. Dentist and dental technician performed the pre-procedure and final timeouts prior to the start of treatment. While preparing tooth #20 for restoration, the dentist turned away to change out a bar in the hand piece and returned to the patient and proceeded to prep tooth #21. Dentist realized the mistake, disclosed it to the patient, and repaired tooth #21 with composite restorative material. Dentist then completed repair of tooth #20 without further complications.

Case 4: A patient, admitted for a right knee arthroscopy with ACL reconstruction, had a sciatic nerve block to the incorrect leg (left). It was immediately noted while positioning the patient for surgery.

10 USC 1102, “Quality Assurance Document under 10 USC 1102. Copies of this document, excluding threats, and information that does not have to be further released under provisions of the law. Unintentional disclosure carries a maximum \$1,000 fine.”



ON THE WEB: <https://www.gmo.amedd.army.mil/ptsafety/pts.htm>





Graphics, Logos, Pamphlets

Posters



Tri-folds



Newsletters/Publications



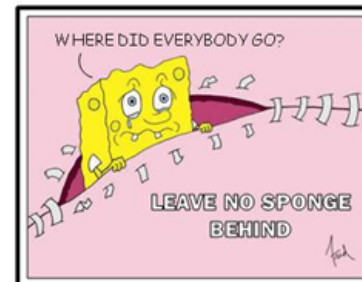
Banners/Displays



Logos/Graphics



Misc.





National Patient Safety Awareness Week

- International Annual Campaign
- Education & Awareness
- Patient Safety Promotion
- Creating Community Awareness
- Display Campaign Logos
- Poster Contest (Medical & Dental)
- \$\$ Prize winners





The Quality Iceberg





Punitive Culture

"Whose fault was it?"

- Focus is on fault
- Assign blame and punish



Accepts the myth:

- *Health care providers should exhibit perfect performance.*



Blaming ignores underlying latent conditions



Retraining disregards the relevance of contributing factors



Punishing encourages people to hide their mistakes





What is a “Just Culture”

- Human Error, At Risk Behavior, Reckless Behavior
- Coaching, Counseling
- Disciplinary Action, Punitive Action, Remedial Action
- Impossibility
- Knowingly Cause Harm, Purpose to Cause Harm
- Performance Shaping Factors
- Substantial and Unjustifiable Risk





Three Behaviors to Create a Just Culture

Goal: To create an environment of non-punitive actions

Human Error	At-Risk Behavior	Reckless Behavior
<p><i>Inadvertent action: slip, lapse, mistake</i></p> <p>Manage through changes in:</p> <ul style="list-style-type: none">• Processes• Procedures• Training• Design• Environment• Behavioral Choices	<p><i>A choice: risk not recognized or mistakenly believed justified</i></p> <p>Manage through:</p> <ul style="list-style-type: none">• Removing incentives for at-risk behaviors• Creating incentives for healthy behaviors• Increasing situational awareness	<p><i>Conscious disregard of a substantial and unjustifiable risk</i></p> <p>Manage through:</p> <ul style="list-style-type: none">• Remedial action• Disciplinary action• Punitive action
Console	Coach	Punish



What's Ahead for Patient Safety?



- Policies
 - VAP
 - CAUTI
- Books, blogs, white papers, conferences, articles....
- Virtual Reality Training gaining acceptance
- Transparency, Apology, Disclosure, Trust (Laws)
- An increase in leading practices
- Patient Safety Research
- Teaming





QMO Site

(www.qmo.amedd.army.mil)



U.S. ARMY MEDICAL DEPARTMENT

Office Of Quality Management

PATIENT SAFETY

[Mission/Vision](#)[Program Goals](#)


MISSION:

Establish an environment of trust, transparency, teamwork and communication to facilitate an interdisciplinary proactive approach to improving safety and preventing adverse events.

VISION:

America's premier Patient Safety Program inspiring trust in Army Medicine

[Policies](#)



Click on the Shopping Cart to visit our on-line shopping system available to Army, Air Force and Navy facilities to replenish supplies of the Clinical Practice Guideline Tool Kits.

Order refill items for multiple CPGs at one time. Check your order status on-line.

Click here to email any questions pertaining to the CPG Shopping Cart including:

changes to your account
questions about orders
forgotten passwords, etc.

[Access To Care](#)[Privacy & Security Notice](#)[External Link Disclaimer](#)[Web Accessibility](#)

Last Modified Date:
Tuesday, July 30, 2013

This site is brought to you by the Quality Management Office, MEDCOM, Headquarters. We are continually assembling information which can be accessed from the menu bar on the left side of the page. We have large quantities of information to publish, and desire to make this site your source for the latest information from our office.

Contact Web Master



medcompssc@amedd.army.mil





ADDITIONAL SLIDES: HARM EVENT STORIES AND CARTOONS



Tragic Cases



Izzy Peterson suffered brain damage after he was given carbon dioxide instead of oxygen after his birth at Tripler.



A third premature baby has died after being given an **overdose** of an anti-clotting drug at Hospital in Indianapolis



...doctors had amputated his right leg above the knee and now they needed to take his left leg, too, to save his life. And all because of a mistake during his gallbladder surgery.



...staff at Virginia Mason injected McClinton with a toxic cleaning solution instead of either saline or the radiological dye routinely administered at the conclusion of the procedure.



Removed Wrong Leg

1995 – 52yo Willie King, who underwent an amputation surgery to remove a diseased leg, but the surgeon removed the wrong one. Dr. Rolando R. Sanchez was the surgeon who was responsible for King's healthy leg. There were a series of mistakes that led to the wrong leg being removed. The wrong leg was listed in a number of key places, such as the blackboard in the operating room, the hospital's computer system and the OR schedule. The wrong leg was already sterilized and prepped for surgery before Sanchez came into the OR. Sanchez claimed that both legs were unhealthy and each would probably have to be removed at some point. However, his medical mistake still cost him \$10,000 in fines, six-month suspension of his medical license and a payment of \$250,000 to King.





Wrong Heart and Lung Transplant

2003 - Surgeons at Duke University Hospital transplanted organs with the wrong blood type into 17-year-old Jesica Santillan. After receiving the wrong heart and lungs, her body began to shut down and she suffered severe brain damage. Dr. James Jagers tried to correct the mistake with a second transplant with the correct blood type, but she died soon after. Santillan was a Mexican immigrant who came to the United States to receive treatment for her life-threatening heart condition. Dr. Jagers accepted responsibility for the tragic mistake, and Duke Hospital has now implemented a double-checking system for all transplantations.





Fertility Clinic Used Wrong Sperm

2004 - Thomas and Nancy Andrews sued New York Medical Services for Reproductive Medicine for negligence and medical malpractice because the clinic accidentally inseminated her eggs with another man's sperm during an in vitro fertilization procedure. When their baby Jessica was born, they noticed that her skin was drastically darker than either of the parents. After three DNA tests, laboratory results confirmed that Thomas Andrews was in fact not Jessica's biological father. The couple continued with the lawsuit and sought unspecified damages against the owner of the clinic and the embryologist who processed the egg and sperm for insemination.





Given Wrong Gas

2005 - Izzy Peterson, Newborn

- C-section at Tripler AMC
- Given CO₂ via mask x 50 min instead of O₂
- 9+ medical personnel (including 3 neonatologists)
- Severe and permanent brain damage
- Family awarded \$16 mil



Izzy Peterson, surrounded by his family in his Texas bedroom recently: His father, Dwight, and mother, Shalay, are next to his pillow.



Unneeded Double Mastectomy

2007 - Darrie Eason, 35, underwent a double mastectomy as directed by two doctors, only to find out that she didn't have breast cancer at all. The mistaken diagnosis stemmed from a lab mix-up, in which a technician mislabeled tissue specimens and the doctor signed off on the diagnosis. Eason even sought a second opinion, but the doctor reiterated her original cancer diagnosis and urged her to have both breasts removed. The New York State Department of Health conducted an investigation to see if the medical laboratory met all safety measures and proper patient care, and found no problems. But Eason is not moving on without a fight. Even though the doctor who signed off on her diagnosis no longer works at the lab, Eason still filed a lawsuit against the facility and sought an undisclosed amount in her case.





Surgery on Wrong Side of Head

2007 - Neurosurgeons at Rhode Island Hospital made not one, but three serious medical mistakes when they performed surgeries on the wrong side of three different patients' heads. Two of the mistakes were caught early enough to close the initial holes and treat the correct side, but the other surgery left an 86-year-old man dead three weeks after the procedure. The surgeon's license was suspended for two months and was back to work shortly after.





Babies Given Accidental Overdose

2007 - Actor Dennis Quaid and his wife Kimberly Buffington received massive media attention not just because their twins were born, but because they nearly died after nurses gave the newborns a lethal dose of heparin to flush their IV catheters and prevent clotting. The babies were undergoing treatment for a staph infection, and instead of giving them the 10 units of heparin recommended for babies, the nurses accidentally gave them an adult dose of 10,000 units. They were bleeding internally and externally and the heparin severely thinned their blood. After 41 hours, their blood began clotting normally and they fully recovered. The mistake stemmed from two main problems: the medications are nearly identical looking and the pharmacy technician accidentally stocked the cabinet with the wrong vials of medicine.





A Slip of the Scalpel

2009 - Colton Reed, 20yo, AF

- Laparoscopic surgery for gallbladder removal
- Aortic artery laceration
- Waited hours to transport to a state hospital vascular surgeon (10a to 5:30p)
- Large blood loss leading to bilateral amputations of both legs





Removed Wrong Testicle

Benjamin Houghton, an Air Force veteran, underwent medical treatment to have his left testicle removed because it was atrophied and may have contained cancer cells. But surgeons at the West Los Angeles VA Medical Center mistakenly removed the right, healthy testicle instead. The medical mistake was traced back to Houghton's medical records, in which there was an error on the consent form and the surgeon failed to mark the correct surgical site before operating. Houghton and his wife sued the West Los Angeles VA Medical Center for \$200,000 in future care needs and unspecified damages.





Surgical Tools Left in Patients

Donald Church underwent surgery at the University of Washington Medical Center in Seattle to have a tumor in his abdomen removed, but doctors forgot to remove a 13-inch retractor in his abdomen after the surgery. This surgical mistake was discovered shortly after the procedure and removed from Church's body without causing any further complications. Church was paid \$97,000 in damages and the UW hospital took full responsibility for the mistake. This error may be rare for most hospitals, but this was the fifth incident in the last five years where UW surgeons have left surgical instruments in patients. Since the 2000 incident, the UW has implemented various surgical procedures to prevent these kinds of surgical mistakes and keep track of their equipment.

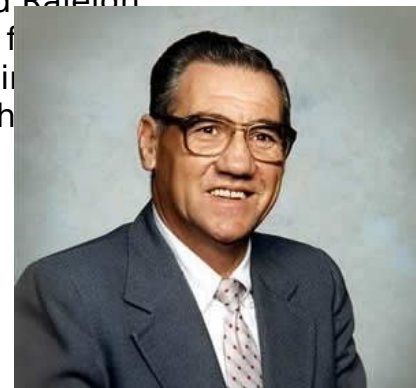




Patients Awake During Surgery



Sherman Sizemore underwent exploratory surgery at Raleigh General Hospital in Beckley, W.Va., to determine the cause of his abdominal pain, but was subjected to much more pain than he could have ever imagined when his anesthesiologist failed to give him general anesthetics until 16 minutes after surgeons first cut into his abdomen. Sizemore could feel the pain, but was unable to move or communicate with surgeons. Following the surgery, Sizemore was haunted by the experience of anesthetic awareness, which affects an estimated 20,000 to 40,000 patients every year, and his tormented memories drove him to commit suicide just two weeks later. Sizemore's family sued Raleigh Anesthesia Associates for failing to properly anesthetize him. The family believes the experience drove their father to suicide.





Unintended Retention of Foreign Object

77-year old Nelson Bailey checked into Good Samaritan Medical Center for surgery to treat his diverticulitis. A foot long sponge that was left in him after surgery and went undiagnosed for five months. It was rotting and causing perforations in his intestines.





Medication Error



COURTESY DOMINIQUE COLEMAN

Alicia Coleman had a feeding tube in her stomach and a chest tube in her vein. A caregiver at a medical daycare mistakenly used the wrong tube and pumped medicine into Coleman's chest instead of her stomach. Coleman died when the medicine stopped her tiny heart.



Case Scenario & Discussion



Doctor believes standard hospital care could have averted the death of his mother



OOPS, UH-OH....



HOSPITAL MEDICAL ERRORS KILL 98,000 AMERICANS EACH YEAR. --- HEARST NEWS INVESTIGATION



OOPS, UH-OH....



HOSPITAL MEDICAL ERRORS KILL 98,000 AMERICANS EACH YEAR. -- HEARST NEWS INVESTIGATION